

gives the clue, as in an adult developing meningo-encephalitis in a family in which a child had recently had parotitis. The course of the disease is usually relatively mild, but sometimes the patient is comatose. Recovery is usually obvious after a few days to a week and the patient is well within a fortnight. There is no specific treatment. Cortisone has been used, but with doubtful success<sup>2</sup>; since spontaneous recovery is the rule, there seems no need to use it except in unusually severe cases.

## REFERENCES

- <sup>1</sup> Russell, R. R., and Donald, J. C., *Brit. med. J.*, 1958, 2, 27.
- <sup>2</sup> Spitznagel, J. K., *Ann. intern. Med.*, 1958, 49, 61.

**Lung Cancer in Non-smokers**

**Q.**—What increase, if any, has there been in the incidence of lung cancer among non-smokers in the past few years?

**A.**—Observations on non-smokers have not as yet been made for a sufficient number of years to provide any direct indication of whether there has been an increase of lung cancer among non-smokers. The observations are difficult to make because the condition is rare and large numbers need to be studied. Estimates of the incidence among non-smokers are higher than the mortality from lung cancer recorded for all persons before about 1935, but there seems little doubt that the early mortality figures substantially underestimated the true incidence. There is some evidence to suggest that the incidence among non-smokers is somewhat higher in large towns than in the countryside (perhaps about two to three times greater<sup>1</sup>), and, although the evidence is not all consistent,<sup>2</sup> it is reasonable to suppose that some real increase may have occurred among non-smokers. If it has, it is unlikely to have been large.

## REFERENCES

- <sup>1</sup> Stocks, P., *Annual Report of the British Empire Cancer Campaign for 1957*, Supplement to Part II, p. 78.
- <sup>2</sup> Doll, R., in *Carcinoma of the Lung*, 1958, edited by R. Bignall, p. 88. Livingstone, Edinburgh.

**Herpes Simplex of the Cornea**

**Q.**—What is the treatment of herpes simplex of the cornea?

**A.**—Although some cases of keratitis due to herpes simplex run a self-limiting course without treatment, others may persist or recur for many months with ultimate blindness or loss of the eye.

The crucial point in treatment is the removal of virus-invaded epithelium and gentle application of a virucidal agent such as iodine, phenol, or ether as early as possible. Atropine is needed. No known antibiotic or chemotherapeutic drug is effective against this virus, and they can do no more than discourage secondary infection.

Steroids may be of value if a stromal or disciform keratitis supervenes, but they increase the danger of recurrence of virus proliferation in the epithelium—furthermore, they mask the symptoms and some of the attendant signs. Such a recurrence must be dealt with by local removal, but, even so, it may damage the eye very severely. Steroids are thus a two-edged weapon, and should only be used in selected cases under the most careful and expert supervision. Some authorities consider that they should never be used in this disease. Therapeutic lamella grafting is very valuable in severe deep herpetic keratitis.

## REFERENCES

- Thygeson, P. Kimura, S. J., and Hogan, M. J., *A.M.A. Arch. Ophthalm.*, 1956, 56, 375.
- Jones, B. R., *Trans. Ophthalm. Soc. U.K.*, 1959, 79, 425.

**Early Rising After Labour**

**Q.**—Why do gynaecologists favour early rising after surgery, but still tend to keep obstetrical cases in bed long enough to cause loss of muscle tone?

**A.**—The questioner's point is not accepted. Early rising after labour was preached as long as 60 years ago, and was commented on in the columns of the *Journal* 10 years

ago.<sup>1</sup> In nearly every maternity unit to-day the patient is encouraged to sit out of bed the day after delivery (even after caesarean section) and thereafter the range of movement is extended daily.

## REFERENCE

- <sup>1</sup> *Brit. med. J.*, 1950, 1, 948.

**Probability of Death of Doctors**

**Q.**—A table in the Government Actuary's report on the N.H.S. Superannuation Scheme<sup>1</sup> shows that the probability of death is on average 50% greater between the ages of 52 and 65 in medical and dental practitioners than in other workers in the Health Service. What might be the explanation of this, and does it reflect the position of practising doctors vis-à-vis the population as a whole?

**A.**—The table referred to by the questioner relates only to the probability of death in service and does not take into account the deaths of those persons who had retired—for whatever reason—and then died. The groups compared with the medical and dental practitioners contain manual and other relatively unskilled workers. Members of this last group—particularly the manual workers—who are unable to maintain their normal efficiency are forced completely to sever their connexion with the service, even though they may take another lighter job elsewhere. A doctor, on the other hand, is always a doctor and will usually remain at work in the National Health Service even though he may ease off. This state of affairs will result in a higher mortality for doctors in service than for other workers in service. In other words, the data, while true so far as they go, should not be used to generalize about the mortality of doctors vis-à-vis the mortality of other workers.

This is borne out by a comparison of the data in this table with those given in the English Life Table No. 11,<sup>2</sup> which shows that the probability of a doctor or dentist dying in service is less than that of the male population as a whole. Perhaps a better comparison is provided by the Registrar-General.<sup>3</sup> This shows that at 55–64 the death rate of medical practitioners was 92% of that for all males; for dental practitioners the ratio was 101%.

## REFERENCES

- <sup>1</sup> *Report of the Government Actuary on the National Health Service Superannuation Scheme, 1948–1955*, 1959, p. 21. H.M.S.O., London.
- <sup>2</sup> Registrar-General, *Decennial Supplement England and Wales, 1951*, Life Tables. H.M.S.O., London.
- <sup>3</sup> Registrar-General, *Decennial Supplement of England and Wales, 1951*, 1958, Occupational Mortality, Part II. H.M.S.O., London.

**Corrections.**—The approved name of "glucophage" (*Brit. med. J.*, March 12, page 798) should have been given as metformin, not methformin.

In the article on "Paediatric Prescribing" by Professor W. Gaisford (March 12, page 794), we regret that the equivalent of 0.5 mg./lb. was incorrectly given as 0.1 instead of 1.0 mg./kg.

The letter on "Mid-stream Urine from Women" (March 26, p. 961) was wrongly attributed to Dr. Elizabeth C. Wood and others. The attribution should have been to Mr. Edwin C. Wood.

The date of death of Dr. Wu Lien-Teh was wrongly given in the obituary notice printed in the *Journal* of February 6 (p. 429): he died on January 21, 1960.

In the paper on "Sedatives for Children" (March 19, p. 871) Professor R. S. Illingworth stated that thalidomide ("distaval") costs about forty times more than chloral. In fact, one tablet of thalidomide (25 mg.) would cost (at hospital prices) approximately thirteen times more than 7½ gr. of chloral.

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